No matter their specialty, location or practice size, physicians are experiencing change in every aspect of their professional lives. In a world increasingly characterized by mobility, personalization, and unprecedented access to information, the movement toward consumerism is transforming the health care system in the same way it is redefining the travel, news publishing, and banking industries.

A whirlwind of new payment programs that employ an evolving array of measures and benchmarks are quickly overtaking decades-old fee-for-service arrangements with both public and private payers. Physicians are also entering into new employment arrangements with hospitals and other employers, which often expand their responsibilities to help shape patient-centered systems within their institutions.

Together, these trends promise a more patient-centered health care system; one that rewards value over volume and requires all players to assess and measure care processes and outcomes. These trends reflect changing expectations and system requirements, forcing every player—physicians, payers and other providers alike—to acquire new capabilities and develop new programs and services. Physicians must develop new competencies and revisit others, adapting the skills acquired through training and practice to a health care environment increasingly characterized by inter-professional teams, the quantification of clinical performance and patient outcomes, shared decision-making and risk-taking.

In April 2015, the American Board of Medical Specialties (ABMS) convened a National Policy Forum to explore the transformation underway and the implications for physicians and their patients. Health care leaders, practice experts, legislative leaders, and other stakeholders joined the ABMS Member Boards Community—consisting of 24 Boards that certify more than 800,000 medical specialists across more than 150 specialties and subspecialties—shared insights and experience, and anticipated the road ahead. Their perspectives about the implications of the movement to patient-centered systems for future medical specialty practice are captured here.
In an era of Fitbits® and retail convenient care clinics, the idea of the patient as a consumer-first being has never been greater.

Tom Main, partner and U.S. market leader for the Health and Life Sciences Practice of Oliver Wyman Group—a global management consulting firm—asked Forum participants to imagine the melding of the $3 trillion health care industry with the $2 trillion lifestyle industry into a $5 trillion combined industry.

For instance, retailers are staking ever-greater ground in the convenient care market where they may meet consumer needs by providing lower-cost clinical services and pharmacist consultations while offering take-home prescriptions and Kleenex and chicken soup. Main says many primary care physicians say that as much as 70 percent of their patient visits do not require a physician and could be handled by physician assistant or nurse practitioner.

In the future, big retail pharmacies like Walgreens, Walmart, CVS and Rite Aid could offer $40 visits and allow scheduling through mobile application with full price, quality and wait-time information, and possibly offer integrated tele-health, biometric monitoring and free health coaching.

And while Main sees retailers as compelling players in the new market—he stresses the importance of patient-centered medical homes where care teams rally around the patient—integrating health and lifestyle medicine and taking the complexity out of the health care system is also critical. Consumers increasingly expect a personalized experience, predictive and preventative services, 24/7 access, evidence based medicine and more transparency around price, quality, experience and outcomes. Consumers will also expect a patient-centered system to go well beyond the clinic walls—and reach all the way into the home, accessible through smartphones and wearable devices.

Ultimately, patient-centered care teams could help high-cost patients with multiple chronic conditions live better, use the emergency department less and get healthier all while lowering the total cost of care, Main says.

“Five years from now, I think people will look back at the ACA and say the fundamental thing that changed was how people bought health care." William Wright, MD

“They’re consumers when they choose us and pay our bills, but patients when they’re under our care.” John R. Combes, MD
Rising health care costs have long been seen as an indicator of an unsustainable system. And while risk-sharing and consumer choice are not new solutions, they are gaining traction among health care purchasers, payers, and providers. Health care’s value proposition—the idea that high-quality and lower-cost care are mutually inclusive—has become a defining system principle.

Within that paradigm, health care stakeholders need to carefully differentiate between expenditures that might be ripe for pruning and the costs of programs and services that actually add value, suggests Mark McClellan, MD, PhD, Senior Fellow and Director of the Initiatives on Value and Innovation in Health Care at the Brookings Institution.

Higher health care expenses, he cautioned, may be money well spent. From improvements in patient outcomes for cardiovascular care to overall lower mortality rates to improved care for low birth-weight babies, advanced technology has helped increase life spans dramatically in recent decades. These improvements have been valuable and costly, and have contributed to rising spending in both the public and private sectors.

Emerging shared risk models may offer providers a major opportunity to innovate to conserve costs and remove low-value care. McClellan says his experiences at the Centers for Medicare & Medicaid Services (CMS) suggest that physicians are deeply engaged in these issues and can be motivated to play a leading role in lowering costs. However, he believes that can only happen if organizations are aligned to engage and help physicians manage their patients’ care as well as the expenses they incur providing needed care.

“The physicians are frustrated. There’s a lot of great eventual potential, but it doesn’t seem all that great to the physicians practicing now.” Mark McClellan, MD

Organizations can better align their resources so physicians can become more engaged in the underlying clinical management models that can truly support value-based care. While accountable care organizations (ACOs) and other new payment models show promise for lowering costs, in practice, incentives have not yet been aligned to help providers shift their care models to effectively tackle the drivers of cost.
ENGAGING PHYSICIANS IN TRANSFORMATION

Throughout the convening, Forum participants noted that economic levers are not the only driver, or even the largest driver, for engaging physicians in the transformation underway. Across the board, speakers and attendees said that physicians must be convinced that new models will help improve care specifically for their patients, and they must also be able to see how their own efforts compare with those of their peers.

Thomas H. Lee, MD, MSc, Chief Medical Officer for Press Ganey Associates, Inc., notes that the availability of transparent information on the patient experience of care can dramatically improve performance. Before patient experience data on all physicians was shared throughout Utah, one percent of Utah doctors placed within the top one percent of physicians nationwide on patient experience scores. After the release of physician-specific data, that number rose to 26 percent. Transparency creates a context for living up to the standards of physicians’ aspirations for professionalism in their interactions with each individual patient, Lee says.

“\nIf you just change the incentives, it’s not enough. What’s the best outcome for the patient?\n”
Glenn D. Steele, MD

Demonstrating Clinical Value to Engage Physicians

Danville, Pa.-based Geisinger Health System, has emerged over the past decade as an innovator in evidence-based clinical delivery models.

Glenn D. Steele, Jr., MD, PhD, outgoing President and CEO of Geisinger Health System, acknowledges that the system, comprised of hospitals, physician groups, and insurance companies, possesses a unique set of advantages for delivering value throughout its system.

But the financial and organizational infrastructure of value-based systems is not enough to assure high-quality patient care. Indeed, Dr. Steele finds that clinicians will only “buy in” to value-based payment systems when they are convinced patient care will improve as a result. In order to do that, Steele notes, it’s imperative to have access to meaningful information about the quality of care provided within the institution.

That underlying philosophy, Steele says, led to and informed the system’s ProvenCare model, which is characterized...
by fixed prices and a standard set of best practices for specific interventions. ProvenCare launched with a care model for coronary artery bypass surgery (CABG), developed through close collaboration with the system’s physicians in 2006.

ProvenCare has since grown to incorporate dozens of conditions, with Wal-Mart contracting to use Geisinger to treat employees needing CABG surgery in 27 states. Geisinger is one of several providers in Wal-Mart’s Centers for Excellence program, which offers Wal-Mart associates care with no out-of-pocket expenses for heart, spine, and transplant surgeries.

The Value Proposition: Perspective from Payers

Physicians are not alone in anticipating and preparing for seismic shifts in the practice environment. In fact, public and private payers are increasingly coming to grips with the fact that the insurance industry as they have known it may not exist in five years.

Much as hospitals are shape-shifting into systems, re-thinking how they can expand their traditional patient care footprints, many insurers are transforming themselves into delivery systems that partner directly with governmental bodies and large employers to provide care, William Wright, MD, MSPH, Executive Medical Director of Colorado Permanente Medical Group, says. In particular, Wright says, the continued “unlocking” of the traditional connection between employment and health care coverage, due to ongoing industry trends as well as the Affordable Care Act’s (ACA) insurance exchanges, has resulted in more individuals making their own purchasing decisions.

To succeed in this new consumer climate, Wright believes insurers will have to partner with providers to ensure they are delivering truly patient-centered care. This care will need to be high quality as a baseline, or as minimal requirements. Further care will need to be delivered in a customer-centric, consumer-focused manner. Physician attributes include not only clinical competence, but also team-based skills and high emotional intelligence. A bad hire is not only hard on patients and staff, but in a system like Kaiser Permanente, the cost impact can be as high as $1.5 Million.

Patrick Conway, MD, MSc, Deputy Administrator for Innovation and Quality and Chief Medical Officer for CMS, offered an inside look at the government’s ongoing efforts to move from the current volume-driven system to a value-based system by improving how care is delivered, providers are paid, and information is distributed.

Dr. Conway discussed the Department of Health and Human Services’ goals for value-based systems, and its intent to link 30 percent of Medicare payments to quality or value through alternative payment models by the end of 2016, and 50 percent by the end of 2018. During the first two years of the Pioneer ACO shared savings programs, participants saved $384 million, and improved in 28 out of 33 quality measures, including 6 out 7 patient experience measures from year 1 to year 2.

But despite major improvements in care, and a wholesale shift in the way health care leaders view their topline goals to more broadly encompass health, Conway says physicians and patients must be engaged if further gains are to be accelerated.

To get there, Conway made a passionate call to engage individual practitioners in the next wave of change. Without support for changes in practice, and without physician involvement in both measure development and quality improvement, Conway said lasting change is improbable.
In an era where physicians are increasingly likely to be employed directly by hospitals and health systems, much of the analysis of that seismic shift has been made in terms of the economic imperative for physicians and hospitals alike. But the change may have even broader implications for how physicians lead from the bedside to the boardroom.

John R. Combes, MD, Senior Vice President and Chief Medical Officer at the American Hospital Association (AHA) and President of the AHA’s Center for Healthcare Governance, notes that leading in this new model requires a greater knack for systemic problem-solving and communication than physicians are traditionally accustomed to, even if they are already used to filling leadership roles.

In an era of risk-based payment models similar to those at Geisinger, physicians are increasingly responsible for managing clinical resources for entire populations. These new responsibilities require physicians to partner more closely with hospitals and other providers, while embracing new competencies in business, management expertise and leadership—from care teams to service lines to the C-Suite.

Stephen Ondra, MD, Senior Vice President and Enterprise Chief Medical Officer at Health Care Service Corporation (HCSC), notes that these shifts will require that providers and insurers alike do more to proactively share data with each other, arguing that transparency is key to effective value-based systems. Ondra noted that insurers are increasingly moving from a focus on claims to one predicated on care management and improvements in outcomes.

At the board level, Combes urges physicians to move from “counting numbers,” or focusing largely on quality metrics and outcomes to helping their organizations identify and solve larger strategic problems. At the institutional leadership level, Combes urges physicians to become more involved in leading partnerships beyond the four walls of their institutions. At an operational level, physicians need to move beyond procedures to focus more on obtaining superior outcomes.
The Need for a Career-Long Commitment to Professionalism

The new environment also requires physicians to redouble their efforts to professionalism. The current definition of the word, with its focus on patient-physician interactions, may be too narrow for the evolving system, says Catherine R. Lucey, MD, Vice Dean for Education at the University of California, San Francisco School of Medicine.

Lucey urges physicians to aspire to professionalism in their relationships with the care team and in the educational environment, while also using it as a motivator to get involved in shaping national policy agendas and addressing the social determinants of health. Similarly, Lucey compares professionalism lapses to medical errors—noting that identifying how both transpire is similar.

In particular, Lucey cites a 2007 article in the Annals of Internal Medicine, which found that while most physicians surveyed agreed with the established domains for professionalism developed by the American College of Physicians and the American Board of Internal Medicine, 45 percent of physicians who had witnessed behavior outside those guidelines had not reported it.

None of the keys to professionalism in the expanded context, Lucey says, are taught in medical school, because much of it relates to their peer-to-peer relationships and not their patient relationships.

Ultimately, Lucey believes professionalism must be seen as an individual competency that can be nurtured, and that lapses in professionalism can be addressed over time. If it’s seen as a label that one earns at the outset of a medical career and is never tended, then the results will resemble the current ones, she believes.

The Road to Patient-Centered Communications

Throughout the Forum, participants drove home the importance of centering care, and systems of care, and the way care is measured, around patients’ needs and expectations. They emphasized that the results patients seek can be entirely different than those that their well-meaning clinicians set out to achieve. To overcome this disconnect, Leana S. Wen, MD, MSc, FAAEM, Commissioner of the Baltimore City Health Department, and Professor and Director of Patient-Centered Care Research at George Washington University (GWU) Department of Medicine, suggests that physicians re-engineer their entire decision-making process to ensure they stay focused on the human aspect of the care they deliver to patients every day.

Wen framed her recommendations by relaying a personal story from her days as an emergency department physician. One afternoon, a man came into her ER from a restaurant

“It is not consistent to say that someone is a terrific doctor except for the fact that they are so nasty when interacting with other professionals or patients.” Catherine R. Lucey, MD
complaining of chest pain. Within two minutes he was shown to a room for evaluation, successfully treated and ultimately released.

The hospital staff viewed the episode, which included a door-to-balloon time (the time from a patient’s initial appearance in the emergency room to the start of the cardiac intervention) of less than 30 minutes, as a clinical and operational success; unparalleled efficiency and expertise. Wen and other hospital staff were taken aback when the patient expressed great dissatisfaction in the treatment he received, complaining that he had not been told he was having a heart attack, that clinicians were running around in a hurry discussing other cases while he was being treated rather than focusing solely on his care.

Though Wen and her colleagues were surprised by the patient’s complaints, she ultimately saw it as a watershed moment in understanding how different perceptions of a single episode of care can be to physicians and patients. Improving communication, Wen says, can be achieved if physicians listen to patients without interruption, explain the care process to patients, explain the thought process behind their care, avoid assumptions about the patient, and ask for their perspective.

As the movement to systems of care continues, participants discussed the increasingly significant role of teams and the attitudes, capabilities and skills essential to team-based practice. Team-based practice, speakers agreed, demands leadership skill and professional behavior and attitudes. It demands the ability to share information across the team and to communicate effectively with patients, engaging them in their care.

Colonel Peter G. Napolitano, MD, FACOG, Program Director for the U.S. Department of Defense’s only Maternal and Fetal Medicine (MFM) fellowship program, reviewed the history and development of the government’s Team-STEPPS training programs, including his involvement in a 15-site, randomized controlled study implementing team training on labor and Delivery for the first time in 2002.

Col. Napolitano, then a physician at one of the implementation sites, recalls being taken aback at first at the efforts requiring a mandatory unit brief at the start of a shift, with physicians, nurses, medical clerks, housekeepers and others staff reviewing the plan of care for the patients for that shift. But quickly he became a believer when he saw the dramatic improvement in communication and reduction in medical errors, including a reduction in the time from calling a Cesarean Section to starting the surgery from 25 to 17 minutes.

“The first thing I tell my team when I’m starting my L&D Shift is, ‘I’m likely going to make a mistake during this shift. It’s your job to help point it out to me and likewise for each of us to do the same with each other. It’s not about me or you, it’s about what’s right for the patient, so check your egos at the door.’” Col. Peter G. Napolitano, MD

Team-Based Practice Takes Off
Since that time, Col. Napolitano says, the Department of Defense has worked closely with the Agency for Healthcare Research and Quality (AHRQ) to spread what ultimately became the TeamSTEPPS approach nationally. Today, the insights from the first pilot project are distilled into four key fundamentals: Communication, Leadership, Situational awareness and Mutual support.

Ultimately, Col. Napolitano says programs like this result in a culture change where inter-professional communication is embraced, where it’s not only acceptable to speak up but is actively encouraged, utilizing tried and true fundamentals based on a similar movement in aviation safety.

“\textit{A majority of the nation’s physicians and the vast majority of hospitals have implemented an EHR. There has been significant progress on adoption, but less progress on information sharing.}”

Janet M. Marchibroda

Capturing, Sharing, and Using Clinical Information

As physicians tackle the demands of a rapidly changing system, usable, timely information will be critical to their efforts to succeed. Janet M. Marchibroda, Director of the Health Innovation Initiative and Executive Director of the CEO Council on Health and Innovation at the Bipartisan Policy Center, explored how clinicians can use clinical informatics to improve their practices at a time when value-based payment models are increasingly focused on outcomes.

Marchibroda believes physicians can reap significant efficiency and quality gains from clinical informatics, but must first secure ready access to information at the point of care; expand their data-sharing efforts in concert with their colleagues and partners; and better engage their patients in their health and health care to review and discuss analytics.

Marchibroda notes that while the $30 billion that has been spent since the passage of the HITECH Act in 2009 – which created incentives for health IT adoption for both physicians, hospitals and other providers—has helped more than over 4,800 hospitals and 433,000 professionals with the adoption of electronic health records, progress on meaningful data sharing has not been made as fast as it may be needed. She adds that she expects that legislation to address some of the related issues around interoperability is likely in the near future.
MEASURING WHAT MATTERS

The journey to value is not without its challenges, though. Several speakers warned of the persistent difficulty of measuring health care quality effectively, a necessity for a workable value-based payment system with a focus on care management and meaningful outcomes improvement.

Robert Berenson, MD, Fellow, the Urban Institute, points to several limitations of current efforts to move from volume- to value-based payment systems, including: the dearth of shared measures, the proliferation of rating systems giving inconsistent results, and concerns about the validity and reliability of metrics. Berenson also brings up the difficulty of measuring intangible, but highly important, concepts like teamwork, culture and leadership.

To address these concerns, Berenson recommends more movement from process to outcomes measurements, measuring care at the organizational level, using measurement to promote learning, investing in the science of measurement development and having a single entity with the responsibility for defining standards for measuring and reporting.

From Performance Measurement to Improvements in Care: A Roadmap

Richard Kronick, PhD, Director of AHRQ, surveyed the challenges in paying physicians for quality. Kronick framed the issue by exploring how performance is measured and rewarded for apple pickers and federal judges, noting that while apple picking can be fairly easily evaluated for effectiveness, the ambiguous nature of measuring the quality and efficiency of justice makes it quite difficult to develop appropriate metrics, and, as a result, payment for federal judges is not based on measured performance.

The challenge for measuring and paying for health care services, Kronick says, is in figuring out where medical care

“What we measure is considered important and worthy of attention. What we can’t or simply don’t measure is marginalized or ignored altogether. ...The research shows that somewhere between 5-15 percent of all encounters in the health care system result in a mis-diagnosis, a missed diagnosis or a non-timely diagnosis. We need to do a lot more in that area.”

Robert Berenson, MD
lies in the measurement continuum. It is clear that some aspects of quality – for example, adverse events – can be measured well, and the ability to measure has contributed to substantial improvements. Kronick notes several major improvements in patient safety in recent years, including an estimated 1.3 million fewer adverse events in 2013 as opposed to 2010 and an 50,000 estimated lives saved. While the causes of the improvement were multi-factorial,

Leveraging the power of legislation to catalyze improvements in care was also the theme of a panel discussion engaging legislative staff involved in the recent passage of the Medicare Access and Children’s Health Improvement Program (CHIP) Reauthorization Act of 2015, which eliminated the Sustainable Growth Rate formula for Medicare physician payment and its yearly threats of payment cuts. Congressional staff said the bill opens up opportunities to discuss changing health care delivery and transformation, by removing a top political obstacle for changing care. Staff members noted the law’s promise for streamlining current federal programs into a more manageable system, as well as provisions for practice improvement assistance. Staff also cited $75 million for quality measure development, support for workforce development, and assistance for community health centers.

“Historically, physicians have been paid like apple pickers. We need to figure out how to pay for value.” Richard Kronick, PhD

Kronick says the work of CMS’ Partnership for Patients, along with the adoption of value-based payment models from CMS and private payers have played a major role in those improvements.

Ultimately, Kronick says, the existence of evidence is critical to catalyzing improvements over time. Changes in payment toward value-based purchasing from CMS have galvanized the attention of hospital leaders.
THE JOURNEY TO PATIENT-CENTERED SYSTEMS: IMPLICATIONS AND CONSIDERATIONS

Participants of the ABMS 2015 National Policy Forum shared a multitude of perspectives on implications of the transformation underway, and its likely impact on patient care and the future of medical specialty practice.

Together, these varied viewpoints illuminate the path forward for a patient-centered system—the call for clinical leadership and physician engagement in the transformation underway, and the essential competencies of patient-centered medical specialty practice.

Forum discussions emphasized physicians’ role, and the role of the ABMS Member Boards community, in assuring patient access to high-quality, safe and effective care by informing and addressing consumer expectations; defining and directing organizational change; and supporting improvement at every level of individual and institutional performance.

During the Forum, speakers and attendees encouraged physicians in their efforts to transform the way they work to lead a more patient-centered system. Key next steps for physicians include:

• Taking advantage of emerging leadership roles
• Learning to adapt new team-based care models and other modes of practice improvement
• Playing a key role in efforts to build meaningful new measures of care, leveraging growing informational technology tools
• Embracing a career-long commitment to professionalism

Ultimately, these opportunities will help physicians lead the charge to a patient-centered system, partnering closely with hospitals, fellow clinicians, and patients along the way.

“If we don’t have physicians leading this work, I don’t think we can succeed.” Patrick Conway
ABMS ACKNOWLEDGES THE CONTRIBUTIONS OF FORUM SPEAKERS:

Brett Baker
Mr. Baker is a member of the Republican staff for the Committee on Ways and Means Subcommittee on Health. His focus is on Medicare Part B, including the systems for making payments to physicians, hospital outpatient departments, ambulatory surgical centers, and dialysis facilities. His portfolio includes delivery models that aim to improve quality and reduce costs, and health information technology (IT) issues. Mr. Baker joined the Subcommittee on Health staff in 2011 after a long tenure with the American College of Physicians where he advocated for internists on payment issues and delivery system reform.

Robert Berenson, MD
Dr. Berenson is an Institute Fellow at the Urban Institute. He is an expert in health care policy, particularly Medicare, and has served in senior positions in two Administrations. Dr. Berenson recently completed a three-year term on the Medicare Payment Advisory Commission (MedPAC), the last two as Vice-Chair. From 1998-2000, he was in charge of Medicare payment policy and private health plan contracting for the Centers for Medicare & Medicaid Services (CMS). Previously, Dr. Berenson served as an Assistant Director of the Carter White House Domestic Policy Staff. Dr. Berenson is Board Certified by the American Board of Internal Medicine (ABIM).

John R. Combes, MD
Dr. Combes is Senior Vice President and Chief Medical Officer at the American Hospital Association (AHA) and President of the AHA’s Center for Healthcare Governance. He also leads the AHA’s Physician Leadership Forum providing education, tools, and information to encourage physician leadership development. As Senior Fellow at the Hospital Research and Education Trust (HRET), Dr. Combes focuses on quality and leadership issues in patient safety, end of life care, and clinical performance improvement. Dr. Combes is Board Certified by the American Board of Internal Medicine (ABIM).

Patrick Conway, MD, MSc
Dr. Conway is the Deputy Administrator for Innovation and Quality and Chief Medical Officer (CMO) for CMS. In this role, he serves as Director of both the Center for Clinical Standards and Quality, and the Center for Medicare and Medicaid Innovation. Dr. Conway is Board Certified by the American Board of Pediatrics (ABP).

Chris Dawe
Mr. Dawe is Managing Director of Policy and Transformation at Evolent Health, a leading provider of value-based care solutions to health systems and physicians. Prior to joining Evolent, Mr. Dawe served as Health Care Policy Advisor to the National Economic Council at the White House. Before joining the Administration, Mr. Dawe served as a Professional Staff Member of the Senate Finance Committee responsible for issues relating to Medicare payment and delivery system reform, health IT, patient-centered outcomes research, and care coordination and QI.
Karen Fisher
Ms. Fisher is Senior Health Counsel with the Senate Finance Committee. She is responsible for Medicare physician and other Medicare Part B issues. Previously, Ms. Fisher was Senior Director and Senior Policy Counsel for the Association of American Medical Colleges (AAMC). Prior to that, Ms. Fisher was General Counsel and Senior Policy Analyst for the Prospective Payment Assessment Commission, a precursor to MedPAC.

Richard Kronick, PhD
Dr. Kronick is Director of the Agency for Healthcare Research and Quality (AHRQ) in the Department of Health and Human Services (HHS). He joined HHS in 2010 as Deputy Assistant Secretary for Planning and Evaluation, overseeing the Office of Health Policy. Dr. Kronick’s work, and that of the Office of Health Policy under his leadership, was integral in the implementation of the Affordable Care Act.

Kevin L. Larsen, MD
Dr. Larsen is Medical Director of Meaningful Use at the Office of the National Coordinator for Health Information Technology (ONC). He leads ONC’s work on quality policy, measurement, and improvement, including clinical decision support and registries. Dr. Larsen is also an Associate Professor of Medicine at the University of Minnesota. Dr. Larsen is Board Certified by the American Board of Internal Medicine (ABIM).

Thomas H. Lee, MD, MSc
As CMO for Press Ganey Associates, Inc., Dr. Lee is responsible for developing clinical and operational strategies to improve the patient experience for health care providers across the nation. He is an internist and cardiologist, and practices primary care at Brigham and Women’s Hospital. Prior to assuming his role at Press Ganey, Dr. Lee was Network President for Partners Healthcare System, the integrated delivery system founded by Brigham and Women’s Hospital and Massachusetts General Hospital. Dr. Lee is Board Certified by the American Board of Internal Medicine (ABIM).

Christoph U. Lehmann, MD, FAAP, FACMI
Dr. Lehmann is a Professor of Pediatrics and Biomedical Informatics at the Vanderbilt University School of Medicine. Dr. Lehmann holds a joint appointment in Biomedical Informatics and is an Adjunct Associate Professor in Health Sciences Informatics at the Johns Hopkins University School of Medicine. He is also a Privat Dozent at the Technische Universitaet Braunschweig in Germany. Dr. Lehmann is Board Certified by the American Board of Pediatrics (ABP) and the American Board of Preventive Medicine (ABPM) with a subspecialty in Clinical Informatics.
Catherine R. Lucey, MD
Dr. Lucey is Vice Dean for Education at the University of California, San Francisco School of Medicine. Previously, she was the interim Dean of the College of Medicine, Vice Dean for Education at the Ohio State University (OSU) College of Medicine, and Associate Vice President for Health Sciences Education for the OSU Office of Health Sciences. Dr. Lucey is a past Chair of the ABIM Board of Directors. Dr. Lucey is Board Certified by the American Board of Internal Medicine (ABIM).

Charlene MacDonald
Charlene MacDonald serves as Senior Policy Advisor for Democratic Whip Steny Hoyer of Maryland. Prior to joining the Whip’s staff last year, Ms. MacDonald worked for Senator Patty Murray (D-WA). Ms. MacDonald has also served as Deputy Chief of Staff and Health Policy Adviser to Representative Allyson Schwartz (D-PA), a member of the House Committee on Ways and Means.

Tom Main
Mr. Main is a partner and U.S. market leader for Oliver Wyman’s Health and Life Sciences practice group and Managing Director of the Oliver Wyman Health Innovation Center. Mr. Main founded the Innovation Center in 2011 to accelerate the health market’s shift from “volume-to-value.” He has collaborated with Adrian Slywotzky on three major thought pieces: The Quiet Healthcare Revolution published in The Atlantic, The Volume-to-Value Revolution, and most recently The Patient-to-Consumer Revolution.

Janet M. Marchibroda
Ms. Marchibroda serves as the Director of the Health Innovation Initiative and Executive Director of the CEO Council on Health and Innovation at the Bipartisan Policy Center. Ms. Marchibroda previously led stakeholder engagement activities for ONC. She also served as the Chief Health Care Officer for IBM and the founding CEO for eHealth Initiative, a non-profit multi-stakeholder organization.

Mark McClellan, MD, PhD
Dr. McClellan is a Senior Fellow and Director of the Initiatives on Value and Innovation in Health Care at the Brookings Institution. He is a former CMS Administrator and former Commissioner of the U.S. Food and Drug Administration (FDA) He previously served as a member of the President’s Council of Economic Advisers and Senior Director for Health Care Policy at the White House, and was an Associate Professor of Economics and Medicine at Stanford University. Dr. McClellan is Board Certified by the American Board of Internal Medicine (ABIM).
Peter G. Napolitano, MD, FACOG
Colonel Napolitano serves as the Program Director for the U.S. Department of Defense’s only Maternal and Fetal Medicine (MFM) fellowship program. He is an Associate Professor of Obstetrics and Gynecology at both the University of Washington and Uniformed Services University of the Health Sciences. Col. Napolitano is Chair Emeritus of the Armed Forces MFM Research Network and serves as advisor to the Centers for Disease Control and Prevention, and the Defense Department’s National Smallpox Vaccination in Pregnancy Registry. Col. Napolitano is Board Certified by the American Board of Obstetrics and Gynecology (ABOG).

Stephen Ondra, MD
Dr. Ondra is Senior Vice President and Enterprise CMO at Health Care Service Corporation. Previously, he served as Senior Vice President and CMO at Northwestern Memorial Hospital. Dr. Ondra served in government as an advisor in the Obama Administration from 2009 to 2012. Prior to joining the Obama Administration, he served on the Veterans Affairs group on the 2008 Obama-Biden Presidential Transition Team. Dr. Ondra is Board Certified by the American Board of Neurological Surgery (ABNS).

Glenn D. Steele, Jr. MD, PhD
Dr. Steele is Board Chair, xC Health Solutions, and the former President and CEO of Geisinger Health System. Dr. Steele previously served as the dean of the Biological Sciences Division at the Pritzker School of Medicine and Vice President for medical affairs at the University of Chicago. Prior to that, he was Professor of Surgery at Harvard Medical School, president and chief executive officer of Deaconess Professional Practice Group, and chairman of the department of surgery at New England Deaconess Hospital. Dr. Steele is Board Certified by the American Board of Surgery (ABS).

Leana S. Wen, MD, MSc, FAAEM
Dr. Wen serves as Commissioner of the Baltimore City Health Department, is a Professor and Director of Patient-Centered Care Research at George Washington University (GWU) Department of Medicine and an Assistant Professor of both Emergency Medicine in the School of Medicine and Health Policy. She co-directs GWU’s Residency Fellowship in Health Policy, and co-leads a new national collaboration on health policy and social mission with Kaiser Permanente. Dr. Wen is Board Certified by the American Board of Emergency Medicine (ABEM).

William Wright, MD, MSPH
Dr. Wright is the Executive Medical Director of Colorado Permanente Medical Group (CPMG). Prior to this position, he was CPMG’s Associate Medical Director of Market and Networks. Dr. Wright serves on the Boards of the Colorado Trust, Colorado Physician Health Program, St. Joseph Hospital Foundation, and Colorado Institute for Family Medicine. He belongs to the American Academy of Family Practice, the Colorado Academy of Family Practice, and the Colorado Medical Society. Dr. Wright is Board Certified by the American Board of Family Medicine (ABFM).
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